The Signal

Vol. 16, No. 3 *Newsletter of the World Association for Infant Mental Health* *July-September 2008*

Perinatal Psychiatry and the Infant Clinician

By
Martin St-André, Associate Clinical Professor of Psychiatry, CHU Ste-Justine and Université de Montréal.

Je marche à côté d'une joie
D'une joie qui n'est pas à moi
D'une joie à moi que je ne puis pas prendre
Je marche à côté de moi en joie

I walk next to joy that is not mine,
a joy I cannot take,
I walk next to myself in joy

St-Denys Garneau,
Accompagnement (1925-1940)
(Free translation, Editor)

In recent years, a number of articles and reviews have been published on the clinical syndromes most prevalent in perinatal psychiatry (Cohen & Nonacs, 2005; Bernazzani et al., 2005; Misri & Kendrick, 2007; Pearlstein, 2008; St-André, in press). Much focus has also been set on the developmental impact of these conditions on the infant (Murray, 1992; Goodman, 2003). More and more, perinatal mood disorders are recognized as clinical conditions frequently affecting future mothers and their infants, and are considered among the most common obstetrical complications. Screening for these is increasingly performed in primary-care and in obstetrical settings, which has permitted developing better-targeted programs for intervening at both the individual and systemic levels with mothers, their infants and their families (Lusskin, Pundiak and Habib, 2007).

The purpose of this short essay is to lay out my personal reflections on some of the challenges currently facing clinicians called upon to treat women with perinatal mood disorders. In particular, I will seek to address the following question: At a time when the utilization of psychotropic medication during pregnancy is becoming progressively more diffused, how do we avoid medicalizing transient symptoms that are better described, conceptualized and treated as manifestations of a developmental crisis?

We know as infant clinicians that there exists no shortcut for transforming the self during the transition to parenthood. This intense period involves reworking attachment relationships, experiencing various losses, deepening marital intimacy, establishing a parental alliance, defining the ideals and goals of becoming a new parent, and reconsidering one's family and cultural heritage. It also entails containing and experiencing the broad range of affects normally encountered with an infant: feelings of joy, awe and wonder, but also feelings of strangeness, ambivalence, and helplessness. The birth of a child and, in turn, one's birth as a parent exposes to the hard light of day that the mystery of life's pursuit is beyond us – a realization that is both wounding and liberating.

As perinatal psychiatrists, we often prescribe psychotropic drugs to help alleviate symptoms of anxiety and depression at critical moments in the transition to parenthood. Medication is often used to protect mothers from relapsing at a most vulnerable time in their life. The reassuring data on the safety of antidepressants (Ramos et al., 2008) and the transient nature of serotoninergic reactions in the newborn (from our group: Ferreira et al., 2007) have rightfully led more physicians to consider psychopharmacotherapy as part of an integrative treatment plan to minimize emotional discomfort during pregnancy and to treat post-natal anxiety and depressive symptoms (Martin & St-André, 2007). Clinical and research data confirm the importance of continuing with antidepressants during pregnancy under many circumstances. Indeed, a high rate of relapse of major depression or anxiety disorder has been observed in women who cease antidepressant use during pregnancy (Cohen et al., 2006). Women have been encouraged, wisely, to fear the ailment more than the cure (Blier, 2006).

It is probably true that, in the past, many women went through pregnancy and the post-natal period with very high levels of untreated mood and anxiety symptoms. Today, however, more and more pregnant women may be prescribed antidepressants and anxiolytics for the symptomatic treatment of transient mood and anxiety symptoms. A recent large-scale epidemiological survey in Québec (Bérard & Oraichi, 2004) revealed that approximately 14% of

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WAIMH
Central Office
Michigan State University • Kellogg Center, Garden Level • East Lansing, MI 48824-1022 • Tel: 517-432-3793 • Fax: 517-432-3694
Finland Office
University of Tampere • Medical Faculty, Finn-Medi 1 • 33014 University of Tampere • Finland • Tel: +358-50-462-7379 • Fax: +358-35517710

women were given antidepressants during the gestational period. This finding underscores the importance of carefully questioning the use and impact of psychotropic medication during pregnancy. Although psychopharmacological and psychotherapeutic approaches have been used complementarily for a long time in psychiatry, the liberalization of psychotropic drug prescribing during pregnancy may lead us to emphasize medical modes of intervention at the expense of supportive, language-based and potentially transformative methods of accompaniment for future parents.

Pregnancy and the perinatal period are times of great transformation and psychic reorganization, a process necessarily accompanied by doubt, uncertainty, and a degree of suffering. In today's society and medical culture, which place great emphasis on autonomy, performance, and the preservation of a stable self-image, developmental tensions are often seen as symptoms to be swiftly eradicated. We are fascinated and seduced by quick technological fixes to various daily and existential problems. Indeed, the utopian promises of neurobiology have raised hopes of somehow being inoculated against moments of distress over the life course. Moreover, the conviction shared by families and clinicians alike that suffering should be prevented at all cost marks a radical departure from traditional Judeo-Christian principles. This shift has allowed elevating psychopharmacological intervention to levels unparalleled in the history of medicine.

The real paradox of this situation is that our concern with preventing "useless suffering" has led a number of clinicians to lose interest in the various layers of meaning that suffering can assume, as is the case during the transition to parenthood. I am not making this point as an oblique and nostalgic reference to the "lost splendour" of the psychoanalytic era, which produced its own reductive views of the complexity of human experience. I am, however, expressing concern over the current trend of medicalizing our understanding of complex developmental processes associated with transformation in parenthood.
In perinatal psychiatry, it has been very gratifying over the years to see that more referrals are made for preventive reasons, for example, regarding the risk of recurrent post-natal depression or the exacerbation of an anxiety disorder. In the absence of a bipolar spectrum disorder diagnosis, most of these prophylactic pharmacological consultations tend to be relatively uncomplicated, medically speaking, given the reassuring data about the safety of antidepressants. The real challenge in these consultations often lies in how mothers and fathers elaborate their anticipations regarding the transition to parenthood (St-André, 1993). In collaboration with family members and with other professionals from the mother-infant program, we try helping future parents find a balance of their own between the frantic pursuit of a "pain-free pregnancy" and the complete rejection of psychological or psychopharmacological support for fear of being declared unfit or ill-prepared for parenthood.

These preventive consultations with a developmental focus yield richer, more integrative clinical encounters than strictly "technical" consultations, but at a price. First, they tend to be more time consuming. Second, they can generate a higher degree of anxiety in parents, compared with the more one-dimensional, psycho-educational, biomedical approach. Indeed, though many future parents often find the themes brought up during sessions surprising and creative, others are frustrated – perhaps even rightfully on occasion – that their depressive tendency or their anxiety is not treated as a straightforward medical complaint. Lastly, though trainees often enjoy the challenge of looking at their patients from multiple clinical angles, they sometimes struggle with a sense of disorientation when trying to organize their case formulations to find a therapeutic focus with the family.

Questionnaires such as the EPDS (Cox, Holdenand & Sagovsky, 1987; Guedeney & Fermanian, 1998) have certainly contributed to screening more women, and now even fathers (Ramchandani et al., 2008), for perinatal depression. However, I have noticed in my practice that similar cross-sectional symptomatic profiles of mothers and fathers can reflect different histories and can follow

The Signal is a quarterly publication of the World Association for Infant Mental Health. Address correspondence to Miri Keren (ofkeren(at)internet-zahav.net).

different courses. The decision to prescribe psychotropic medication should thus be made after the clinical picture is examined in a diligent, rigorous and longitudinal manner. Hence, we should not be over-reliant on certain clinical scales, however validated.

When referrals are made for established anxiety or mood episodes, a challenge that we face is discriminating real mood episodes from other transient states. Often, mothers and fathers experience a transitory developmental crisis as unacceptable and shameful, perceiving it as a sign of weakness. Over the years, mothers have requested from me antidepressant treatments on the desire to go back to work sooner, to "look happy" despite a flailing relationship, or to regain their previous "performance" level more quickly. Although not the norm, these examples highlight the difficulty that some families have fully accepting the emotional costs of a transformative experience. By definition, a developmental crisis creates the possibility to reach a new level of psychic equilibrium, but this can occur only if time and effort is spent to confront change.

A new line of investigation now impacting how aggressively we treat antenatal depression and anxiety concerns the effects of antenatal stress on infant development. This emerging field has generated a plethora of contributions over the past few years (O'Connor et al., 2002; Talge et al., 2007; Ogren & Lombroso, 2008). This literature has been of great interest to validate clinical intuition about the importance of protecting the emotional well-being of mothers during a most critical time not only for the neural and emotional development of the unborn child but also for its later development during infancy. It has also raised awareness of the importance of epigenetic factors in infant development, which had already been surmised from the transactional perspective on development (Sameroff & Chandler, 1975). Future mothers and fathers who, increasingly, are familiar with the latest internet, press and parent-blog information on infant development often receive these new epidemiological findings with a mix of apprehension, guilt, shame and anxiety. If there is any irony in the situation today, it is that while parents are better informed than ever about perinatal mood disorders, the appropriate human, community or psychotherapeutic resources to help them are hard to come by.

The emotional accompaniment of future parents is influenced in no small measure by the resource shortage in obstetrics and the lack of time (and compensation) for organizing efficient multidisciplinary discussions centred on perinatal emotional factors. Obstetrical teams are more and more solicited to provide the most cutting-edge technical care to pregnant women. Unfortunately, this can squeeze the amount of time that medical and front-line professionals have at their disposal to address the emotional needs of pregnant women and their partners (Molénat, 2003; Vander Linden & Roegiers, 2004). Together, these factors can potentially lead to the overuse of psychotropic medication at the expense of other modes of intervention such as increased supportive care by obstetrical teams and referral to community groups and psychotherapeutic resources. Though costly and time consuming, these are essential for meeting the emotional needs of pregnant women, their infants and families.

Another issue that arises in perinatal psychiatry relates to role compartmentalization. This is something that occurs not only between disciplines, but also between subdisciplines. For example, many infant physicians circumscribe their work as pertaining exclusively to the parent-infant relationship and, therefore, systematically refuse to prescribe medication to mothers or fathers who suffer from post-natal depression or severe anxiety. In geographic areas where primary care physicians are currently in short supply, as is the case in many regions of Québec, this can lead to the under-treatment of affected mothers and fathers. The same holds true for parents who manage to build only a very tenuous relationship with infant teams but who are reluctant to consult for their own sake outside child psychiatric settings. Needless to say, the problem could be remedied in good part through greater training for child psychiatrists, family physicians and pediatricians in the treatment of common perinatal psychiatric conditions.

Role compartmentalization is reflected also in the tendency by adult psychiatrists and family physicians to conceptualize and treat post-natal depression as primarily or exclusively an individual problem. Here, too, insufficient training may be at fault, this time in systemic approaches that include the rest of the family, particularly the infant, in the treatment process. The emerging field of women's psychiatry, for its part, may be facing the same challenges as obstetrics: Minimal training is provided in parental role development, fathering, and the specifics of infant development and psychopathology. Again, more training in infant development, early relationship disorders and infant psychopathology for adult psychiatrists and obstetricians would go a long way to improving the situation. The idea here is not to negate the differences in clinical skills and perspectives that are much needed across the various professionals intervening during the perinatal period. Rather, it is essential that we minimize the significant variations in care that frequently occur as a function of the primary contact clinician that a family encounters.

The variety of treatments now available to address perinatal depression and anxiety has the potential to help parents and infants during a most critical period of development. The challenge of balancing a medical-psychiatric view with a more developmentally based approach has become a capital issue for perinatal and infant psychiatrists. We may have reached a point where the pendulum needs to swing back towards a greater emphasis on accompanying families rather than intervening medically. Our scientific meetings and journals are rich sources of evidence-based data that provide the empirical signposts to guide our practices. However, a broader voice might be needed in our field to discuss clinical, interpersonal and epistemological issues that are a critical component of our work as infant clinicians.

About the author: Martin St-André is associate clinical professor of psychiatry, CHU Ste-Justine and Université de Montréal. He is the current President of the Association Québécoise pour la Santé Mentale des Nourrissons (WAIMH-Quebec).
martin.st-andre@umontreal.ca

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